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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CHERYL DIANE BOYD,** **a.k.a. CHERYL DIANE ARTIAGA** **2715 South 269th Street** **Kent, WA 98032** **Registered Nurse License No. 326819** **Public Health Nurse Certificate No. 35251** Respondent.	Case No. 2010-375 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 31, 1981, the Board issued Registered Nurse License Number 326819 to Cheryl Diane Boyd, also known as Cheryl Diane Artiaga ("Respondent"). On August 20, 1994, Respondent's registered nurse license was revoked, as set forth in paragraph 4 below. The revocation was stayed and Respondent was placed on probation for three (3) years on terms and conditions. Respondent's registered nurse license expired on January 31, 2009.

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3. On or about October 31, 1983, the Board issued Public Health Nurse Certificate Number 35251 to Respondent. Respondent's public health nurse certificate expired on January 31, 2009.

DISCIPLINARY ACTION BY THE BOARD

4. On July 20, 1994, pursuant to the Proposed Decision of the Administrative Law Judge ("ALJ") adopted by the Board as its Decision in the disciplinary proceeding titled *In the Matter of the Accusation Against: Cheryl Diane Boyd,* etc., Case No. 93-31, the Board revoked Respondent's registered nurse license effective August 20, 1994. The revocation was stayed and Respondent was placed on probation for three (3) years on terms and conditions. The ALJ determined that on July 31, 1993, while employed at Robert F. Kennedy Medical Center, Respondent failed to correctly chart the administration of the controlled substance Demerol on the nursing notes and medication administration records of various patients, constituting cause for discipline against Respondent's registered nurse license pursuant to Business and Professions Code ("Code") sections 2761, subdivision (a) (unprofessional conduct), and 2762, subdivision (e) (false or grossly incorrect, grossly inconsistent, or unintelligible entries in hospital or patient records).

STATUTORY PROVISIONS

5. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

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7. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Disciplinary Actions by the State of Washington

Nursing Care Quality Assurance Commission)

9. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the State of Washington, Department of Health, Nursing Care Quality Assurance Commission ("Commission"), as follows:

a. On or about March 16, 1999, pursuant to the Ex Parte Order of Summary Action in the disciplinary proceeding titled *In the Matter of the License to Practice Registered Nursing of: Cheryl D. Boyd,* Docket No. 99-03-A-1020RN, the Commission summarily suspended Respondent's license to practice as a registered nurse in the state of Washington (hereinafter "Washington license") pending further disciplinary proceedings by the Commission. The Ex Parte Order indicates that on March 19, 1997, the Commission issued a Statement of Charges against Respondent, alleging that she engaged in unprofessional conduct in violation of RCW 18.130.180(5). The charges were based on the Board's Decision, set forth in paragraph 4 above.

On December 3, 1997, the Commission entered into a stipulated settlement with Respondent, Stipulated Findings of Fact, Conclusions of Law and Agreed Order ("Agreed Order"). Pursuant to the Agreed Order, the Commission suspended Respondent's license for 12 months, but stayed the suspension provided that Respondent comply with certain conditions. The Commission determined that Respondent failed to comply with almost all of the conditions of the Agreed Order, as more particularly set forth in subparagraph (b) below, and that Respondent's conduct warranted summary action to protect the public health, safety, or welfare. A true and correct copy of the Ex Parte Order of Summary Action is attached as exhibit "A" and incorporated herein by reference.

b. On or about August 24, 1999, in the disciplinary proceeding set forth in subparagraph (a) above, Respondent and the Commission entered into a stipulated settlement, Stipulated Findings of Fact, Conclusions of Law and Agreed Order, whereby Respondent's Washington license was suspended indefinitely. A true and correct copy of the Stipulated Findings of Fact, Conclusions of Law and Agreed Order is attached as exhibit "B" and incorporated herein by reference. The Commission and Respondent stipulated to the following facts or acknowledged that the evidence was sufficient to justify the following findings:

1. On December 18, 1997, Respondent was evaluated by a Commission-approved substance abuse evaluator. Respondent failed to provide a copy of the Agreed Order to the evaluator prior to the evaluation as required.

2. Between approximately March 17 and April 17, 1998, Respondent was employed as a registered nurse at Benson Heights Rehabilitation Center ("Benson Heights"). Respondent failed to request prior approval of this employment from the Commission, failed to notify Benson Heights of the existence of the Agreed Order and provide the facility with a copy of the Order, and worked as a charge nurse without direct supervision. Respondent was terminated from her employment once Benson Heights discovered that she had been disciplined by the Commission.

3. Respondent applied for employment at Swedish Medical Center ("Swedish"). Respondent failed to list Benson Heights as a previous employer on her application. Swedish

hired Respondent and assigned her to work on the Addiction Recovery Services inpatient alcohol and drug detoxification and medical stabilization unit. On November 22, 1998, Respondent worked the evening shift at Swedish as the Detox Nurse which required that all detox patients be checked every hour, that all patient's vital signs be taken, and that any detox medications be administered. During Respondent's shift, staff members noticed that Respondent was behaving strangely, that her speech was slurred, and that she had problems ambulating. Respondent complained of feeling ill and went to the staff lounge to lie down at approximately 9:00 p.m. At approximately 10:40 p.m., a staff member went to the lounge and found Respondent unresponsive with shallow breathing. Respondent was sent to the emergency department where she immediately responded after receiving a Narcan IV push (a narcotic antagonist) followed by 1 mg of Romazicon. Respondent refused to allow any urine or blood tests even though she was informed she could be terminated for her refusal. The evening shift narcotic count on November 22, 1998, revealed a shortfall of 15.5 milliliters of liquid methadone. During her shift on November 22, 1998, Respondent failed to document hourly rounds after 4:00 p.m. and failed to make any notations for some patients since the start of her shift. Respondent subsequently admitted that she took 20 cc of liquid methadone while on duty at Swedish.

4. On December 11, 1998, Respondent sent a letter to the Commission, requesting reinstatement of her Washington license. On December 18, 1998, Respondent sent another letter to the Commission, notifying them that she had resigned from her position at Swedish. Respondent failed to indicate in either letter that she was suspected of diversion or use of drugs while working at Swedish, or that she was threatened with dismissal for failing to submit to blood or urine tests.

5. On December 17, 1998, Respondent underwent a urinalysis test and tested positive for cannabinoids.

c. On or about February 14, 2006, pursuant to the Stipulated Findings of Fact, Conclusions of Law and Agreed Order on Modification in the disciplinary proceeding set forth in subparagraph (a) above, Respondent's Washington license was reinstated, but subject to probation commencing on the date of entry of the Order on Reinstatement. Condition 4.4 of

Respondent's probation states, in pertinent part, that Respondent shall seek a substance abuse evaluation through the Washington Health Professional Services (WHPS) program and then, if recommended, enter and comply with all aspects of that program. If Respondent fails to cooperate with WHPS during the initial substance abuse evaluation or comply with any aspect of the program thereafter, it would be a violation of the Agreed Order on Modification and may result in the Commission taking further disciplinary action against Respondent's license. A true and correct copy of the Stipulated Findings of Fact, Conclusions of Law and Agreed Order on Modification is attached as exhibit "C" and incorporated herein by reference.

d. On or about May 15, 2008, pursuant to the Findings of Fact, Conclusions of Law and Order on Non-Compliance in the disciplinary proceeding set forth in subparagraph (a) above, the Commission suspended indefinitely Respondent's Washington license due to her failure to comply with Condition 4.4 of the probation order set forth in subparagraph (c) above. A true and correct copy of the Findings of Fact, Conclusions of Law, and Order on Non-Compliance is attached as exhibit "D" and incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 326819, issued to Cheryl Diane Boyd, also known as Cheryl Diane Artiaga;

2. Revoking or suspending Public Health Nurse Certificate Number 35251, issued to Cheryl Diane Boyd, also known as Cheryl Diane Artiaga;

3. Ordering Cheryl Diane Boyd, also known as Cheryl Diane Artiaga, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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4. Taking such other and further action as deemed necessary and proper.

DATED: 2/8/10

LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2009102469
accusation.rtf

EXHIBIT A

EX PARTE ORDER OF SUMMARY ACTION

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice Registered Nursing of: CHERYL D. BOYD, R.N., RN00128956, Respondent.	)	Docket No. 99-03-A-1020RN EX PARTE ORDER OF SUMMARY ACTION

This matter came before Nursing Care Quality Assurance Commission (Commission) on March 16, 1999, on an Ex Parte Motion for Order of Summary Action (the Motion). The Presiding Officer for the Commission was Eric B. Schmidt, Senior Health Law Judge. The Commission members deciding the Motion were: Joanna Boatman, R.N.; Ellen Rosbach, R.N.; Roberta Schott, L.P.N.; and Jeni Fung, Public Member. The Commission reviewed the Motion and the documents submitted in support of the Motion and enters the following:

Section 1: FINDINGS OF FACT

1.1 Cheryl D. Boyd, R.N. (Respondent) is a registered nurse, licensed by the State of Washington at all times applicable to this matter.

1.2 The Commission issued a Statement of Charges alleging Respondent violated RCW 18.130.180(1), (4), (6), (7), (9), (13), (23)(b), and WAC 246-840-710(1)(a)-(c), (4)(a), (b), (d). The Statement of Charges was accompanied by all other documents required by WAC 246-11-250.

REDACTED

1.3 On March 19, 1997, the Commission issued a Statement of Charges against Respondent's license alleging that the Respondent had engaged in unprofessional conduct in violation of RCW 18.130.180(5). The charges were based on an order of the state of California Board of Registered Nursing, dated July 20, 1994, which revoked Respondent's California nursing license, stayed the revocation, and placed her California license on probation for three years subject to numerous conditions. The California order found that Respondent failed to accurately chart the administration of Demerol to patients on July 31, 1993.

1.4 On December 3, 1997, the Commission entered Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order) in settlement of the March 19, 1997 Statement of Charges. The Agreed Order suspended Respondent's license for twelve months, and stayed the suspension provided Respondent comply with certain conditions, including that Respondent obtain a substance abuse evaluation and comply with the recommendations of the evaluator. The evaluator did not recommend any treatment for substance abuse, but to ensure Respondent's reports were accurate, recommended she submit to random urinalysis tests if she was going to work in nursing.

1.5 The alleged conduct, as set forth in the Allegations below and as supported by the documents attached to the Motion, is directly related to Respondent's ability to practice safely as a registered nurse in the state of Washington. The Commission finds, based on declarations and evidence submitted with the Motion, that a summary suspension of Respondent's license to practice as a registered nurse is only such action as is necessary to prevent or avoid immediate danger to the public health, safety, or welfare.

REDACTED

Section 2: ALLEGATIONS

2.1 Respondent was hired by Swedish Medical Center on August 18, 1998, and assigned to work in the Addiction Recovery Services Center in the Ballard neighborhood of Seattle. On November 22, 1998, Respondent was called to work the evening shift in the position of Detox Nurse, with responsibilities to check patients every hour, take their vital signs, and administer detox medications as needed.

2.2 During Respondent's shift, staff members noticed that Respondent was behaving unusually. Respondent was observed as eating at a rapid pace while continuing to talk rapidly, having problems ambulating, slurring her speech, and later observed as sedated and sleepy. The evening shift team then suggested that Respondent go to the staff lounge and rest, which she did at approximately 9:00 p.m. At approximately 10:40 p.m., a staff member checked in on Respondent and found her unresponsive with shallow respiration. Respondent's airway was checked to see if it was clear, and several large chunks of candy were found lodged in Respondent's mouth.

2.3 The emergency department was called for assistance and staff administered to Respondent intravenous Narcan©, a narcotic antagonist, followed by Romazicon©, after which she immediately responded. Staff attempted to obtain blood and urine samples and Respondent pulled out her IV and refused to submit to any tests. Respondent appeared extremely agitated and insisted on going home. During this time Respondent berated the emergency staff and repeatedly thanked Jesus for saving her life. Respondent was informed of Swedish's policy relating to suspected drug use among employees, and the requirement for urine and blood testing, and continued to refuse to submit. Against medical advice, Respondent left the hospital with her husband.

REDACTED

2.4 After Respondent left, staff discovered that Respondent had failed to document any of her hourly rounds after 4:00 p.m., and failed to make any notations for some patients since the start of her shift. It was also discovered that 15.5 milliliters of methadone were unaccounted for on Respondent's unit. Respondent later admitted in her written statement to the Commission, that she had taken 20 cc of methadone from Swedish during her shift on November 22, 1998.

2.5 On November 23, 1998, Respondent called her supervisor and indicated that she had consulted with her physician and the previous day's episode may have resulted from a diabetic crisis or thyroid problem. Respondent submitted her letter of resignation to Swedish on December 8, 1998.

2.6 Since Respondent has been under the conditions of the Agreed Order, she has failed to comply with almost all of the conditions. Respondent was required to obtain a substance abuse evaluation, which she did, but she did not provide a copy of the Agreed Order to the evaluator at the beginning of the December 18, 1997 evaluation until pushed on the subject by the evaluator.

2.7 The evaluator indicated that the test results were inconsistent, therefore the evaluator requested Respondent provide three letters of reference from people who had known her for at least two years attesting to Respondent's responsible non-use of alcohol. Respondent did not provide these letters promptly, and caused a lengthy delay in the submission of the evaluation report to the Commission. The report was submitted to the Commission on May 5, 1998, four months after the evaluation, in violation of the terms of the Agreed Order.

REDACTED

2.8 Respondent also failed to comply with the Agreed Order which required she obtain prior approval for all employment, advise any potential employers of the Agreed Order and work only under direct supervision. Between approximately March 17 and April 17, 1998, Respondent obtained employment as a charge nurse at Benson Heights Rehabilitation Center without prior approval from the Commission and without notifying Benson Heights of the Agreed Order. She was terminated once Benson discovered the existence of the Agreed Order.

2.9 Respondent then continued with this misrepresentation by failing to list Benson Heights as a prior employer on her application for employment at Swedish Medical Center. And after resigning from Swedish following the circumstances described above, Respondent failed to bring these circumstances to the Commission's attention, but instead simply provided notification that she had resigned and requested that her nursing license be reinstated. Respondent made this request for reinstatement, and subsequently her urinalysis test result was positive for the presence of cannabinoids. In response to this positive result, she again denies any drug use.

Section 3: CONCLUSIONS OF LAW

3.1 The Commission has jurisdiction over Respondent's license to practice registered nursing.

3.2 The Commission has authority to take emergency adjudicative action to address an immediate danger to the public health, safety, or welfare. RCW 34.05.422(4), RCW 34.05.479, RCW 18.130.050(7), and WAC 246-11-300.

3.3 The above Findings of Fact and Allegations establish:

REDACTED

(a) The existence of an immediate danger to the public health, safety, or welfare;

(b) That the requested summary action adequately addresses the danger to the public health, safety, or welfare; and

(c) The requested summary action is necessary to address the danger to the public health, safety, or welfare.

3.4 The requested summary suspension is the least restrictive agency action justified by the danger posed by Respondent's continued practice of registered nursing.

3.5 The above Findings of Fact and Allegations establish conduct, which warrants summary action to protect the public health, safety, or welfare.

Section 4: ORDER

Based on the above Findings of Fact, Allegations and Conclusions of Law, the Commission enters the following order:

4.1 IT IS HEREBY ORDERED that the license of Respondent to practice as a registered nurse in the state of Washington is summarily suspended pending further disciplinary proceedings by the Commission.

DATED THIS 16th DAY OF MARCH, 1999.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION

JOANNA BOATMAN, R.N., Panel Chair

REDACTED

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBERS:

98-12-0023RN
OPS NO. 97-04-22-815RN

REDACTED

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Cheryl Boyd
Docket No.: 99-03-A-1020 RN
Document: Statement of Charges

Regarding your request for information about the above-named practitioner, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

NONE

If you have any questions or need additional information regarding the information that was withheld, please contact:

Adjudicative Clerk Office
P.O. Box 47879
Olympia, WA 98504-7879
Phone: (360) 236-4677
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to Nancy Ellison, Deputy Secretary, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice Registered Nursing of CHERYL D. BOYD, RN, RN00128956, Respondent.	)	Docket No. 99-03-A-1020RN STATEMENT OF CHARGES

The Program Manager of the Washington State Nursing Care Quality Assurance Commission, on designation by the Commission, makes the allegations below, which are supported by evidence contained in program case file(s) No. 98-12-0023RN.

Section 1: ALLEGED FACTS

1.1 Cheryl D. Boyd, Respondent was issued a license to practice registered nursing by the State of Washington in January, 1998.

1.2 On March 19, 1997, the Commission issued a Statement of Charges against Respondent's license alleging that the Respondent had engaged in unprofessional conduct in violation of RCW 18.130.180(5). The charges were based on an order of the state of California Board of Registered Nursing, dated July 20, 1994, which revoked Respondent's California nursing license, stayed the revocation, and placed her California license on probation for three years subject to numerous conditions. The California order found that Respondent failed to accurately chart the administration of Demerol to patients on July 31, 1993.

1.3 On December 3, 1997, the Commission entered Stipulated Findings of Fact,

Conclusions of Law and Agreed Order (Agreed Order) in settlement of the March 19, 1997 Statement of Charges. The Agreed Order suspended Respondent's license for twelve months, and stayed the suspension provided Respondent comply with certain conditions, including that:

(a) Respondent shall obtain a substance abuse evaluation, provide a copy of the Agreed Order to the evaluator prior to the evaluation, and cause the evaluator to submit the evaluation report to the Commission within 60 days of the evaluation;

(b) Respondent shall abide by all treatment recommendations of the evaluator;

(c) Respondent shall notify the Commission of any employment in the health care field, obtain approval of the Commission prior to accepting employment, notify any current or prospective employer of the Agreed Order and provide a copy of the Agreed Order to the employer;

(d) Respondent shall only be employed as a nurse where she is subject to direct supervision, and shall not function as supervisor, head nurse or charge nurse; and

(e) Respondent shall obey all laws and rules governing the practice of nursing in the state of Washington.

1.4 On December 18, 1997, Respondent was evaluated by a Commission approved substance abuse evaluator. Respondent failed to provide a copy of the Agreed Order to the evaluator prior to the evaluation.

1.5 After the December 18, 1997 evaluation, Respondent failed to promptly comply with the evaluator's requirement that she provide three letters of reference from individuals who have known her for at least two years and could attest to Respondent's responsible non-use of alcohol. The delay in providing these letters of reference resulted in the evaluator's delay in providing the evaluation report to the Commission. On May 5, 1998, the Commission

REDACTED

received a copy of the substance abuse evaluation report, over four months after the date of the evaluation.

1.6 Between approximately March 17 and April 17, 1998, Respondent was employed as a registered nurse at Benson Heights Rehabilitation Center. Respondent failed to request prior approval of this employment from the Commission, failed to notify Benson Heights of the existence of the Agreed Order and provide a copy of the Agreed Order, and worked as charge nurse without direct supervision. Respondent worked at Benson Heights until the disciplinary action taken by the Commission was discovered, at which time she was terminated.

1.7 By application for employment at Swedish Medical Center dated July 14, 1998, Respondent failed to list Benson Heights as a previous employer. Swedish hired Respondent on August 18, 1998, and assigned her to work on the Addiction Recovery Services inpatient alcohol and drug detoxification and medical stabilization unit at Swedish Medical Center in Ballard.

1.8 On November 22, 1998, Respondent worked the evening shift at Swedish as the Detox Nurse, which required that all detox patients be checked every hour, that all patient vital signs be taken, and that any detox medications be administered.

1.9 During Respondent's shift, staff members noticed that Respondent was behaving strangely, that her speech was slurred and she had problems ambulating. Respondent complained of feeling ill and went to the staff lounge to lie down at approximately 9:00 p.m. At approximately 10:40 p.m., a staff member went to the staff lounge and found Respondent unresponsive and with shallow breathing. Respondent was sent to the emergency department where she immediately responded after receiving a Narcan IV push (a narcotic antagonist),

REDACTED

followed by 1 mg of Romazicon. Respondent refused to allow any urine or blood tests even though she was informed she could be terminated for her refusal.

1.10 The evening shift narcotic count on November 22, 1998, revealed a shortfall of 15.5 milliliters of liquid methadone.

1.11 During her shift on November 22, 1998, Respondent failed to document hourly rounds after 4:00 p.m., and failed to make any notations for some patients since the start of her shift.

1.12 On November 23, 1998, Respondent called Swedish and indicated she had contacted her physician and that the previous day's episode could be the result of a diabetic crisis or thyroid problem.

1.13 Though initially denying any misuse of drugs, Respondent subsequently admitted that while on duty at Swedish Hospital, she had taken 20 cc of liquid methadone.

1.14 By letter to the Commission of December 11, 1998, Respondent requested reinstatement of her nursing license. By letter to the Commission of December 18, 1998, Respondent notified the Commission that she had resigned from her position at Swedish Medical Center. In both letters Respondent failed to indicate that she was suspected of diversion or use of drugs while working at Swedish, or that she was threatened with dismissal for failure to submit to blood or urine tests.

1.15 On December 17, 1998, Respondent's urinalysis test result was positive for the presence of cannabinoids.

Section 2: ALLEGED VIOLATIONS

2.1 The violations alleged in this section constitute grounds for disciplinary action pursuant to RCW 18.130.180 and the imposition of sanctions under 18.130.160.

2.2 The facts alleged in paragraphs 1.3 through 1.15 constitute unprofessional conduct in violation of RCW 18.130.180(9).

2.3 The facts alleged in paragraphs 1.6 and 1.7 constitute unprofessional conduct in violation of RCW 18.130.180(1) and (13).

2.4 The facts alleged in paragraphs 1.8 through 1.13 constitute unprofessional conduct in violation of RCW 18.130.180(1), (4), (6), (23)(b).

2.5 The facts alleged in paragraphs 1.8 through 1.13 constitute unprofessional conduct in violation of RCW 18.130.180(7) and WAC 246-840-710(4)(a), (b), (d).

2.6 The facts alleged in paragraphs 1.8 and 1.11 constitute unprofessional conduct in violation of RCW 18.130.180(7) and WAC 246-840-710(1)(a)-(c).

2.7 The facts alleged in paragraph 1.14 constitute unprofessional conduct in violation of RCW 18.130.180(1), (2) and (13).

2.8 The facts alleged in paragraph 1.15 constitute unprofessional conduct in violation of RCW 18.130.180(4), (6) and (23)(b).

The full texts of the alleged violation are as follows:

RCW 18.130.180 Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder or applicant under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a

REDACTED

license or in reinstatement thereof;

. . .

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

. . .

(6) The possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

. . .

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

. . .

(23) Current misuse of:

. . .

(b) Controlled substances; or

. . . .

WAC 246-840-710 Violations of standards of nursing conduct or practice. The following will serve as a guideline for the nurse as to the acts, practices, or omissions that are inconsistent with generally accepted standards of nursing conduct or practice. Such conduct or practice may be grounds for action with regard to the license to practice nursing pursuant to chapter 18.79 RCW and the Uniform Disciplinary Act, chapter 18.130 RCW. Such conduct or practice includes, but is not limited to the following:

(1) Failure to adhere to the standards enumerated in WAC 246-840-700(1) which may include:

(a) Failing to assess and evaluate a client's status or failing to institute nursing intervention as required by the client's condition.

(b) Willfully or repeatedly failing to report or document a client's symptoms, responses, progress, medication, or other nursing care accurately and/or intelligibly.

(c) Willfully or repeatedly failing to make entries, altering entries, destroying entries, making incorrect or illegible entries and/or making false entries in records pertaining to the giving of medication, treatments, or other nursing care.

(d) Willfully or repeatedly failing to administer medications and/or treatments in accordance with policy and procedure.

REDACTED

Section 3: NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare and constitute a probability of death or bodily harm. The Program Manager of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline pursuant to RCW 18.130.180 and the imposition of sanctions under 18.130.160.

DATED this 17th day of March, 1999.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION

Diane E Vincent

SHARON SULLIVAN ECKHOLM
WSBA No. 20866
Assistant Attorney General Prosecutor

soc.wp
6/96

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBERS:
98-12-002RN

REDACTED

EXHIBIT B

STIPULATED FINDINGS OF FACT,
CONCLUSIONS OF LAW AND AGREED ORDER

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice Registered Nursing of CHERYL BOYD, RN RN00128956 Respondent.	Docket No. 99-03-A-1020RN STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER

The Nursing Care Quality Assurance Commission, by and through Sharon Sullivan Eckholm, Assistant Attorney General Prosecutor and Cheryl Boyd, RN, stipulate and agree to the following:

Section 1: Procedural Stipulations

1.1 Cheryl Boyd, Respondent, was issued a license to practice registered nursing by the State of Washington in January 1998.

1.2 On March 16, 1999 the Nursing Care Quality Assurance Commission issued a Statement of Charges against Respondent and issued an Order of Summary Action suspending Respondent's license to practice as a registered nurse.

1.3 The Statement of Charges alleges that Respondent engaged in unprofessional conduct in violation of RCW 18.130.180(1), (2), (4), (6), (7), (9), (13), (23)(b) and WAC 246-840-710(1)(a)-(c), (4)(a), (b), (d).

1.4 Respondent understands that the State is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.5 Respondent understands that she has the right to defend herself against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.6 Respondent understands that, should the State prove at a hearing the allegations in the Statement of Charges, the Nursing Care Quality Assurance Commission has the power and authority to impose sanctions pursuant to RCW 18.130.160.

1.7 Respondent and the Nursing Care Quality Assurance Commission agree to expedite the resolution of this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.8 Respondent waives the opportunity for a hearing on the Statement of Charges contingent upon signature and acceptance of this Agreed Order by the Nursing Care Quality Assurance Commission.

1.9 This Agreed Order is not binding unless and until it is signed and accepted by the Nursing Care Quality Assurance Commission.

1.10 Should this Agreed Order be signed and accepted it will be subject to the reporting requirements of RCW 18.130.110 and any applicable interstate/national reporting requirements.

1.11 Should this Agreed Order be rejected, Respondent waives any objection to the participation at hearing of all of the Commission members or the Health Law Judge who heard the Agreed Order presentation.

REDACTED

Section 2: Stipulated Facts

The State and Respondent stipulate to the following facts or acknowledge that the evidence is sufficient to justify the following findings:

2.1 On March 19, 1997 the Commission issued a Statement of Charges against Respondent's license alleging that the Respondent had engaged in unprofessional conduct in violation of RCW 18.130.180(5). The charges were based on an order of the state of California Board of Registered Nursing dated July 20, 1994 which revoked Respondent's California nursing license, stayed the revocation, and placed her California license on probation for three years subject to numerous conditions. The California order found that Respondent failed to accurately chart the administration of Demerol to patients on July 31, 1993.

2.2 On December 3, 1997 the Commission entered Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order) in settlement of the March 19, 1997 Statement of Charges. The Agreed Order suspended Respondent's license for twelve months and stayed the suspension provided Respondent comply with certain conditions, including that:

(a) Respondent shall obtain a substance abuse evaluation, provide a copy of the Agreed Order to the evaluator prior to the evaluation, and cause the evaluator to submit the evaluation report to the Commission within 60 days of the evaluation;

(b) Respondent shall abide by all treatment recommendations of the evaluator;

REDACTED

(c) Respondent shall notify the Commission of any employment in the health care field, obtain approval of the Commission prior to accepting employment, notify any current or prospective employer of the Agreed Order and provide a copy of the Agreed Order to the employer;

(d) Respondent shall only be employed as a nurse where she is subject to direct supervision, and shall not function as supervisor, head nurse or charge nurse; and

(e) Respondent shall obey all laws and rules governing the practice of nursing in the state of Washington.

2.3 On December 18, 1997 Respondent was evaluated by a Commission-approved substance abuse evaluator. Respondent failed to provide a copy of the Agreed Order to the evaluator prior to the evaluation as required.

2.4 Between approximately March 17 and April 17, 1998 Respondent was employed as a registered nurse at Benson Heights Rehabilitation Center. Respondent failed to request prior approval of this employment from the Commission, failed to notify Benson Heights of the existence of the Agreed Order and provide a copy of the Agreed Order, and Respondent worked as charge nurse without direct supervision. Respondent worked at Benson Heights until the disciplinary action taken by the Commission was discovered, at which time she was terminated.

2.5 By application for employment at Swedish Medical Center dated July 14, 1998, Respondent failed to list Benson Heights as a previous employer. Swedish hired Respondent on August 18, 1998 and assigned her to work on the Addiction Recovery

REDACTED

Services inpatient alcohol and drug detoxification and medical stabilization unit at Swedish Medical Center in Ballard.

2.6 On November 22, 1998, Respondent worked the evening shift at Swedish as the Detox Nurse which required that all detox patients be checked every hour, that all patient vital signs be taken, and that any detox medications be administered.

2.7 During Respondent's shift staff members noticed that Respondent was behaving strangely, that her speech was slurred and that she had problems ambulating. Respondent complained of feeling ill and went to the staff lounge to lie down at approximately 9:00 p.m. At approximately 10:40 p.m. a staff member went to the staff lounge and found Respondent unresponsive and with shallow breathing. Respondent was sent to the emergency department where she immediately responded after receiving a Narcan IV push (a narcotic antagonist) followed by 1 mg of Romazicon. Respondent refused to allow any urine or blood tests even though she was informed she could be terminated for her refusal.

2.8 The evening shift narcotic count on November 22, 1998 revealed a shortfall of 15.5 milliliters of liquid methadone.

2.9 During her shift on November 22, 1998 Respondent failed to document hourly rounds after 4:00 p.m. and failed to make any notations for some patients since the start of her shift.

2.10 On November 23, 1998 Respondent called Swedish and indicated she had contacted her physician and that the previous day's episode could be the result of a

REDACTED

diabetic crisis or thyroid problem.

2.11 Though initially denying any misuse of drugs, Respondent subsequently admitted that she had taken 20 cc of liquid methadone while on duty at Swedish Hospital.

2.12 By letter to the Commission dated December 11, 1998 Respondent requested reinstatement of her nursing license. By letter to the Commission dated December 18, 1998 Respondent notified the Commission that she had resigned from her position at Swedish Medical Center. In both letters Respondent failed to indicate that she was suspected of diversion or use of drugs while working at Swedish, or that she was threatened with dismissal for failure to submit to blood or urine tests.

2.13 On December 17, 1998 Respondent's urinalysis test result was positive for the presence of cannabinoids.

Section 3: Conclusions of Law

The State and Respondent agree to the entry of the following Conclusions of Law:

3.1 The Nursing Care Quality Assurance Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 The above facts constitute unprofessional conduct in violation of RCW 18.130.180(1), (2), (4), (6), (7), (9), (13), (23)(b) and WAC 246-840-710(1)(a)-(c), (4)(a), (b), (d).

3.3 The above violations are grounds for the imposition of sanctions under RCW 18.130.160.

Section 4: Agreed Order

Based on the preceding Stipulated Facts and Conclusions of Law, the Commission hereby ORDERS:

4.1 The license to practice as a registered nurse in the state of Washington held by Cheryl Boyd shall continue to be SUSPENDED and is hereby SUSPENDED INDEFINITELY from the date of this Order.

4.2 Respondent shall not make public appearances representing self as a licensed registered nurse.

4.3 Respondent shall not violate any law or regulation regarding the practice of registered nursing.

4.4 Respondent may submit a written request for modification of the Commission's Order upon compliance with the following conditions:

a. Respondent need not personally appear before the Commission.

b. Respondent shall continue with a Commission-approved substance abuse treatment program. Prior to requesting modification of this Order, Respondent shall complete the Commission-approved substance abuse treatment program and cause the treatment provider to submit a report/discharge summary directly to the Commission. Respondent shall provide a copy of this Order to the treatment provider and ensure that the treatment provider makes reference to the Order in the report/discharge summary. The report/discharge summary shall include the treatment plan, objectives, progress and prognosis of the treatment.

REDACTED

c. Respondent must show total and complete abstinence from all mood and mind altering substances, including any drugs legally prescribed to her, for a continuous twelve (12) month period prior to requesting modification.

d. Respondent must show satisfactory compliance with the terms and conditions imposed in this Order.

e. The Commission may impose additional conditions after reviewing the reports submitted and reviewing the Respondent's compliance with this Order.

4.5 Respondent shall assume all costs of complying with this Order.

4.6 Respondent shall appear in person for interviews with the Commission or its designee upon reasonable notice.

4.7 Respondent shall immediately execute all release of information forms as may be required by the Commission or its designee.

4.8 Respondent shall inform the Nursing Care Quality Assurance Commission, in writing, of changes in her residential address.

4.9 Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

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REDACTED

I, Cheryl Boyd, Respondent, certify that I have read this Stipulated Findings of Fact, Conclusions of Law and Agreed Order in its entirety; that my counsel of record, if any, has fully explained the legal significance and consequence of it; that I fully understand and agree to all of it; and that it may be presented to the Nursing Care Quality Assurance Commission without my appearance. If the Nursing Care Quality Assurance Commission accepts the Stipulated Findings of Fact, Conclusions of Law and Agreed Order, I understand that I will receive a signed copy.

Cheryl Boyd

CHERYL BOYD
Respondent

8/9/99
Date

REDACTED

Section 5: Order

The Nursing Care Quality Assurance Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order.

DATED this 24TH day of August, 1999.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION

Cheryl C Pizzano RN MPA

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION

SHARON SULLIVAN ECKHOLM
WSBA # 20866
Assistant Attorney General Prosecutor

8-16-99
Date

FOR INTERNAL USE ONLY. INTERNAL TRACKING NUMBERS:

98-01-004RN

REDACTED

EXHIBIT C

STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER ON MODIFICATION

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Registered Nurse of: CHERYL BOYD, RN License No. RN00128956 Respondent.	Docket No. 99-03-A-1020RN STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW AND AGREED ORDER ON MODIFICATION

The Nursing Care Quality Assurance Commission (Commission), by and through Marc Defreyn, Department of Health Staff Attorney, and Respondent, Cheryl Boyd, represented by counsel, if any, stipulate and agree to the following:

Section 1: PROCEDURAL STIPULATIONS

1.1 Respondent is licensed to practice as a registered nurse in the state of Washington.

1.2 On August 24, 1999, the Commission entered a Stipulated Findings of Fact, Conclusions of Law and Agreed Order (August 1999, Agreed Order) In the Matter of the License to Practice as a Registered Nurse of Cheryl Boyd (Docket Number 99-03-A-1020RN). This 1999 Order suspended Respondent's license indefinitely.

1.3 On or about October 19, 2005, Respondent requested, in writing, modification of the terms of the August 1999, Agreed Order.

1.4 A member of the Commission reviewed Respondent's request and proposed modification of the terms of the August 1999, Agreed Order as set out in Section 4 below.

1.5 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order on Modification (Agreed Order on Modification).

1.6 Respondent waives the opportunity for a hearing on the request for modification provided that the Commission accepts this Agreed Order on Modification.

1.7 Respondent understands that this Agreed Order on Modification is not binding unless and until it is signed and accepted by the Commission.

1.8 If the Commission accepts this Agreed Order on Modification, it is subject to the federal reporting requirements pursuant to Section 1128E of the Social Security Act and 45 CFR Part 61, RCW 18.130.110 and any other applicable interstate/national reporting requirements. It is a public document and will be available on the Department of Health web site.

1.9 If the Commission rejects this Agreed Order on Modification, Respondent waives any objection to the participation at hearing of any Commission members who heard the Agreed Order on Modification presentation.

Section 2: FINDINGS OF FACT

The State and Respondent stipulate to the following facts:

2.1 Cheryl Boyd, Respondent, was issued a license to practice as a registered nurse by the state of Washington in January 1998. Respondent's license is suspended.

2.2 On August 24, 1999, the Commission entered a Stipulated Findings of Fact, Conclusions of Law and Agreed Order (August 1999, Agreed Order) In the Matter of the License to Practice as a Registered Nurse of Cheryl Boyd (Docket Number 99-03-A-1020RN). The Findings of Fact in the August 1999 Agreed Order were:

A. On March 19, 1997, the Commission issued a Statement of Charges against Respondent's license alleging that the Respondent had engaged in unprofessional conduct in violation of RCW 18.130.180 (5). The charges were based on an order of the state of California Board of Registered Nursing dated July 20, 1994, which revoked Respondent's California nursing license, stayed the revocation, and placed her California license on probation for three years subject to numerous conditions. The California order found that Respondent failed to accurately chart the administration of Demerol to patients on July 31, 1993.

B. On December 3, 1997, the Commission entered into a Stipulated Findings of Fact, Conclusions of Law and Agreed Order (Agreed Order) in settlement of the March 19, 1997, Statement of Charges. The Agreed Order suspended Respondent's license for twelve months and stayed the suspension provided Respondent comply with certain conditions, including that:

1. Respondent shall obtain a substance abuse evaluation, provide a copy of the Agreed Order to the evaluator prior to the evaluation, and cause the evaluator to submit the evaluation report to the Commission within 60 days of the evaluation;

2. Respondent shall abide by all treatment recommendations of the evaluator;

3. Respondent shall notify the Commission of any employment in the health care field, obtain approval of the commission prior to accepting employment, notify any current or prospective employer of the Agreed Order and provide a copy of the Agreed Order to the employer;

4. Respondent shall only be employed as a nurse where she is subject to direct supervision, and shall not function as a supervisor, head nurse or charge nurse; and

5. Respondent shall obey all laws and rules governing the practice of nursing in the state of Washington.

2.3 On December 18, 1997, [redacted]

2.4 Between approximately March 17 and April 17, 1998, Respondent was employed as a registered nurse at Benson Heights Rehabilitation Center. Respondent failed to request prior approval of this employment from the Commission, failed to notify Benson Heights of the existence of the Agreed Order and provide a copy of the Agreed Order, and Respondent worked as charge nurse without direct supervision. Respondent worked at Benson Heights until the disciplinary action taken by the Commission was discovered, at which time she was terminated.

2.5 By application for employment at Swedish Medical Center dated July 14, 1998, Respondent failed to list Benson Heights as a previous employer. Swedish hired Respondent on August 18, 1998 and assigned her to work on the Addiction Recovery Services inpatient alcohol and drug detoxification and medical stabilization unit at Swedish Medical Center in Ballard.

2.6 On November [redacted] 1998, Respondent worked the evening shift at Swedish as the Detox Nurse which required that all detox patients be checked every hour, that all

patient vial signs be taken, and that any detox medications be administered.

2.7 During Respondent's shift, staff members noticed that Respondent was behaving strangely, that her speech was slurred and that she had problems ambulating. Respondent complained of feeling ill and went to the staff lounge to lie down at approximately 9:00 p.m. At approximately 10:40 p.m. a staff member went to the staff lounge and found Respondent [redacted]

2.8 The evening shift narcotic count on November [redacted] 1998, revealed a shortfall of 15.5 milliliters of liquid methadone.

2.9 During her shift on November [redacted] 1998, Respondent failed to document hourly rounds after 4:00 p.m. and failed to make any notations for some patient since the start of her shift.

2.10 On November [redacted] 1998, Respondent called Swedish and indicated she had contacted her physician and that the previous day's episode could be the result of a [redacted]

2.11 Though initially denying any misuse of drugs, Respondent subsequently admitted that she had taken 20 cc of liquid methadone while on duty at Swedish Hospital.

2.12 By letter to the Commission dated December 11, 1998, Respondent requested reinstatement of her nursing license. By letter to the Commission dated December 18, 1998, Respondent notified the Commission that she had resigned from her position at Swedish Medical Center. In both letters Respondent failed to indicate that she was suspected of diversion or use of drugs while working at Swedish, or that she was threatened with dismissal for failure to submit to blood or urine tests.

2.13 On December [redacted] 1998, Respondent's [redacted]

2.14 On or about October 19, 2005, Respondent requested, in writing, modification of the terms of the August 1999, Agreed Order.

Section 3: CONCLUSIONS OF LAW

The State and Respondent agree to the entry of the following Conclusions of Law:

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (2), (4), (6), (7), (9), (13), (23)(b) and WAC 246-840-710(1)(a)-(c), (4)(a), (b), (d).

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

3.4 This Agreed Order on Modification supersedes the August 1999 Agreed Order.

Section 4: AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order on Modification:

4.1 Respondent's license is REINSTATED but subject to PROBATION, commencing the date of entry of this Order on Reinstatement provided Respondent meets all licensing requirements. The conditions of probation include:

4.2 Respondent shall ensure that all licenses received during the term of probation are stamped "probation" and shall immediately return any license to the Commission that is not stamped "probation".

4.3 Respondent may not practice as a RN except as part of a Commission-approved refresher course.

A. Upon acceptance to the course, Respondent shall immediately notify the Commission and provide contact information for the course instructor.

B. Respondent shall enter only ONE refresher course. Respondent may not drop out and re-enroll, or enroll in a different refresher program.

C. This order in no way requires a refresher course to accept Respondent, and grants no special rights or privileges to Respondent during the time Respondent is enrolled in the course. Respondent must abide by all rules and policies of the course and governing institutions. Respondent must pass the course according to the same standards set for any other course participant.

D. Respondent agrees that the refresher course instructor may share information on Respondent's progress with the Commission. In addition, Respondent agrees that the refresher program may share information concerning Respondent with clinical site coordinators.

E. Clinical facilities must be notified of and provided a copy of this Order and are not required to grant a request for participation in a clinical rotation. Ultimately, it is Respondent's responsibility to find a suitable clinical site.

F. Respondent shall provide three (3) copies of this Agreed Order on Modification to the refresher course instructor. Respondent shall cause the instructor to furnish written confirmation to the Commission that a copy of the Agreed Order on Modification has been provided.

G. Respondent must provide proof of successful completion of the approved refresher course within ten (10) months of the effective date of this Agreed Order on Modification by submitting supporting documents to:

Nursing Care Quality Assurance Commission
Attention: Compliance Officer
P.O. Box 47864
Olympia, WA 98504-7864

PROVIDED, HOWEVER, should Respondent fail to submit proof of successful completion of the refresher course within the required time frame, Respondent's license is automatically SUSPENDED upon the passage of ten (10) months after the effective date of this Agreed Order on Modification.

4.4 Respondent shall seek a substance abuse evaluation through the Washington Health Professional Services (WHPS) program and then, if recommended, enter and comply with all aspects of that program. If Respondent fails to cooperate with WHPS during the initial substance abuse evaluation or comply with any aspect of the program thereafter, it will be a violation of this Agreed Order on Modification and may result in the Commission taking further disciplinary action against Respondent's license. Respondent must contact the WHPS program and begin the evaluation process on or before thirty (30) days from the date of entry of this Agreed Order on Modification. Respondent shall sign a release that allows the WHPS program to provide the

Commission monitoring records and/or reports pertaining to her participation in the program.

4.5 Respondent may submit a written request for modification upon successful completion of the WHPS program. Respondent must at that time be prepared to provide proof of satisfactory compliance with the terms and conditions imposed in this Agreed Order on Modification. Respondent must personally appear before the Commission at any such hearing, however, at the discretion of a Reviewing Commission Member, the terms and conditions of this Agreed Order on Modification may be modified through an Agreed Order, or Respondent's license reinstated without a hearing. Upon notice and an opportunity for Respondent to be heard, the Commission may impose additional conditions after reviewing the documents submitted and reviewing Respondent's compliance with this Agreed Order on Modification.

4.6 Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.7 Respondent is responsible for all costs of complying with this Agreed Order on Modification.

4.8 Respondent shall inform the Commission and the Adjudicative Service Unit, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

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Section 5: FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the credential after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the credential should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

Section 6: ACCEPTANCE

I, Cheryl Boyd, Respondent, have read, understand and agree to this Agreed Order on Modification. This Agreed Order on Modification may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order on Modification.

Cheryl Boyd

CHERYL BOYD
Respondent

1/23/06

Date

_____, WSBA#

Attorney for Respondent

_____

Date

Section 7: ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law and Agreed Order on Modification.

DATED: 21 Feb 06, 2006.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY
ASSURANCE COMMISSION

Marian Williams
Panel Chair

Presented by:

Marc Defreyn, WSBA#28318
Department of Health Staff Attorney

14 FEB 2006
Date

FOR INTERNAL USE ONLY: PROGRAM NO. 98-12-0023RN

EXHIBIT D

FINDINGS OF FACT, CONCLUSIONS OF LAW
AND ORDER ON NON-COMPLIANCE

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
SECRETARY OF HEALTH

In the Matter of: CHERYL BOYD, Credential No. RN00128956, Respondent.	Docket No. 99-03-A-1020RN Master Case No. M1999-62241 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER ON NON-COMPLIANCE

APPEARANCES:

Respondent, Cheryl Boyd, pro se

Department of Health Nursing Program, by
Jack Eastman Bucknell, Department Staff Attorney

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

This matter came before the Presiding Officer on a motion to suspend the Respondent's credential for failure to comply with the terms and conditions of the final order. The motion was filed by the Department on April 15, 2008. The hearing was held on May 14, 2008. CREDENTIAL SUSPENDED.

ISSUE

Whether Respondent's failure to comply with an order dated February 14, 2006 justifies suspension of Respondent's credential.

SUMMARY OF EVIDENCE

The following witness testified: Mary Dallman, Case Manager, Washington Health Professional Services (WHPS).

The following exhibits were admitted:

Exhibit A: A copy of the WHPS Monitoring Contract, dated March 27, 2006.

Exhibit B: A copy of the memorandum from WHPS dated February 26, 2008.

Exhibit C: A copy of the March 3, 2008 letter mailed to the Respondent.

Based upon the evidence presented, the Presiding Officer enters the following:

I. FINDINGS OF FACT

1.1 The Respondent was issued a credential to practice as a registered nurse in the State of Washington in January 1998.

1.2 On February 14, 2006, the disciplining authority entered a Stipulated Findings of Fact, Conclusions of Law and Agreed Order on Modification (February 2006 Agreed Order on Modification) in this matter directing the Respondent to undergo an evaluation with the WHPS Program and, if recommended, enter into a contract with the program and comply with all aspects of the program. The order included a notice that if the Respondent failed to comply with the terms and conditions of the February 2006 Agreed Order on Modification, such conduct could result in suspension of her credential.

1.3 The Respondent's credential is subject to compliance with the terms and conditions identified in the February 2006 Agreed Order on Modification.

1.4 When the Respondent failed to comply with the terms and conditions of the February 2006 Agreed Order on Modification, the Department moved for a hearing

on non-compliance requesting that a suspension be imposed for the Respondent's

failure to comply with Paragraph 4.4 of the order. The Department provided declarations (with attachments) from the Department's compliance officer and the WHPS case manager.

1.5 The Presiding Officer convened a hearing on the motion on May 14, 2008, and considered the testimony and exhibits presented.

1.6 The February 2006 Agreed Order on Modification required the Respondent to undergo an evaluation with WHPS and, if recommended, enter into a contract with the program and comply with all aspects of the program, designed to protect the public. RCW 18.130.160.

1.7 Based on the evidence presented, the Respondent failed to comply with the terms and conditions of the February 2006 Agreed Order on Modification.

II. CONCLUSIONS OF LAW

2.1 The Commission (and by designated authority, the Presiding Officer) has continuing jurisdiction over Respondent to ensure compliance with the terms and conditions of the February 2006 Agreed Order on Modification. The Presiding Officer has jurisdiction over the subject matter of this proceeding, pursuant to chapter 18.79 RCW, and the Uniform Disciplinary Act, chapter 18.130 RCW.

2.2 The Respondent has been credentialed to practice as a registered nurse in the state of Washington at all times material to the proceeding, subject to the terms and conditions of the February 2006 Agreed Order on Modification.

2.3 The Findings of Fact demonstrate that the Respondent failed to comply with the terms and conditions of the February 2006 Agreed Order on Modification. The

Respondent has not established good cause for that failure. As a result, the Respondent's credential should be suspended.

III. ORDER

Based on the foregoing Summary of Evidence, Findings of Fact, and Conclusions of Law, the Respondent's credential to practice as a registered nurse is SUSPENDED INDEFINITELY. At such time as the Respondent has complied with the terms and conditions of the February 2006 Agreed Order on Modification, the Respondent may petition for reinstatement of the credential.

Dated this 15th day of May, 2008.

JOHN F. KUNTZ, Health Law Judge
Presiding Officer

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate/national reporting requirements. If adverse action is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either Party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this Order with:

Adjudicative Clerk Office
PO Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Nursing Program
PO Box 47864
Olympia, WA 98504-7864

The request must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Clerk Office has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, however, the 30-day period will begin to run upon the resolution of that petition. RCW 34.05.470(3).

The order remains in effect even if a petition for reconsideration or petition for review is filed. "Filing" means actual receipt of the document by the Adjudicative Clerk Office. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
CHERYL DIANE BOYD aka CHERYL DIANE ARTIAGA 4701 Claire Del Avenue Long Beach, CA 90807	No: 93-31 L-61003
Registered Nurse Lic. No. 326819,	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitle matter.

This Decision shall become effective August 20, 1994.

IT IS SO ORDERED July 20, 1994.

BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By /s/ Harriett W. Clark, Esq.
President

btm

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CHERYL DIANE BOYD aka CHERYL DIANE ARTIAGA 4701 Claire Del Avenue Los Beach, California 90807 Registered Nurse License No. 326819, Respondent.	Case No. 93-31 OAH No. L-61003

PROPOSED DECISION

This matter came on regularly for hearing before Jaime René Román, Administrative Law Judge of the Office of Administrative Hearings, in Los Angeles, California, on April 22, 1994.

The complainant was represented by Gary M. James, Deputy Attorney General.

Respondent Cheryl Diane Artiaga aka Cheryl Diane Boyd (hereinafter "Respondent") appeared personally and represented herself.

Evidence was received, and the matter submitted on April 22, 1994.

FINDINGS OF FACT

The Administrative Law Judge finds the following facts:

1. On August 27, 1992, Catherine M. Puri, R.N., Ph.D., made and filed the Accusation in her official capacity as Executive Officer, Board of Registered Nursing, Department of Consumer Affairs, State of California. No testimonial or documentary evidence on the Accusation was received. On October 6, 1993, Ruth Ann Terry, R.N., M.P.H., made and filed the First Supplemental Accusation in her official capacity as Executive Officer, Board of Registered Nursing (hereinafter "Board"), Department of Consumer Affairs, State of California.

2. On March 31, 1981, the Board issued registered nurse license number 326819 to Respondent.

3. On July 22, 1993, Respondent commenced fulltime employment at Robert F. Kennedy Medical Center (hereinafter "the Medical Center"). Without any formal orientation, Respondent commenced patient care under the supervision of a mentor.

A. On July 31, 1993, at 0800, Respondent failed to correctly chart the administration of 75 mg. of Demerol, a controlled substance, on the nursing notes of patient B.G. by failing to chart the reason the medication was administered. No competent evidence established that Respondent falsely entered on patient B.G.'s medication administration record the order for Demerol.

B. On July 31, 1993, at 1200, Respondent failed to correctly chart the administration of 75 mg. of Demerol, a controlled substance, on the nursing notes of patient B.G. by failing to chart the reason the medication was administered. No competent evidence established that Respondent falsely entered on patient B.G.'s medication administration record the order for Demerol.

C. On July 31, 1993, at 1400, Respondent failed to correctly chart the actual administration of 75 mg. of Demerol, a controlled substance, on the medication administration record of patient I.B.

D. On July 31, 1993, at 1700, Respondent failed to correctly chart the administration of 75 mg. of Demerol, a controlled substance, on the nursing notes of patient C.F. by failing to chart the reason the medication was administered.

E. On July 31, 1993, at 1800, Respondent failed to correctly chart the actual administration of 75 mg. of Demerol, a controlled substance, on the medication administration record of patient I.B.

F. On July 31, 1993, at 1830, Respondent failed to correctly chart the actual administration of 75 mg. of Demerol, a controlled substance, on the nursing notes of patient C.F. and the medication administration record of patient C.F.

4. On August 2, 1993, Respondent was terminated from the Medical Center. No competent evidence established the cause of Respondent's termination. In order to eliminate any suspicion by her employer that she had been personally abusing Demerol or any other controlled substance, Respondent unsuccessfully requested, prior to termination, that her blood or urine be tested. No competent evidence established that Respondent

diverted any controlled substance while employed at the Medical Center.

5. Although Respondent had been licensed as a registered nurse for over twelve years at the time of the conduct set forth in Finding No. 3, she testified that she had been recently hired and had received no orientation or training in the Medical Center's policies and procedures relating to the writing of notes. At no time did Respondent possess keys to any controlled substances while employed at the Medical Center. Respondent readily and candidly acknowledged that she failed to enter correct entries into the records set forth in Finding No. 3, but mitigates her conduct by an unfamiliarity borne from a lack of proper training and experience at the Medical Center. Respondent, a recent widow, is a self-supporting mother of two children. She expresses great pride in her licensure and established that she has the potential to practice safe nursing.

DETERMINATION OF ISSUES

Pursuant to the foregoing Findings of Fact, the Administrative Law Judge makes the following Determination of Issues:

1. Cause for the suspension or revocation of Respondent's license as a registered nurse exists pursuant to the provisions of Business and Professions Code sections 2761(a) and 2762(e) in that Respondent made incorrect entries in hospital records as set forth in Finding No. 3.

2. The objective of a disciplinary proceeding relating to licensing privileges is to protect the public, the profession, to maintain the integrity of the profession and high professional standards and preservation of public confidence. These proceedings are not for the primary purpose of punishing an individual. (Camacho v. Youde (1979) 95 Cal.App.3d 161, 165.) Giving due consideration to the facts and circumstances as set forth in Finding No. 3, including evidence of mitigation and rehabilitation as set forth in Finding Nos. 4 and 5, the public interest will not be adversely affected by the issuance of a properly conditioned license as a registered nurse.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The license and licensing rights of Respondent as a registered nurse under the Nursing Practice Act is revoked; provided, however, revocation is stayed and Respondent is placed on probation for three (3) years upon the following terms and conditions:

1. Respondent shall obey all federal, state and local laws, and all rules and regulations of the Board governing the practice of nursing in California. A full and detailed account of any and all violations of law shall be reported by the Respondent to the Board in writing within seventy-two (72) hours of occurrence.

2. Respondent shall fully comply with the terms and conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the Respondent's compliance with the Program.

3. Respondent, during the period of probation, shall appear in person as directed by the Board or its designated representative.

4. Periods of residency or practice outside of California will not apply to the reduction of this probationary term. The Respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state.

5. Respondent, during the period of probation, shall submit such written reports, declarations and verification of actions under penalty of perjury as are required. These reports, declarations and verification of actions shall contain statements relative to Respondent's compliance with all the terms and conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

6. Respondent, during the period of probation, shall engage in the active practice of professional nursing in California for a minimum of twenty-four (24) hours per week (or as determined by the Board or its designated representative) for six (6) consecutive months.

7. The Board shall be informed of and approve of each agency for the which the Respondent provides nursing services prior to Respondent's commencement of work. The Respondent shall inform his employer of the reason for and the terms and conditions of probation and shall provide a copy of the Board's Decision and order to his employer and immediate supervisor. The employer shall submit performance evaluations and other reports as requested by the Board. Respondent is also required to notify the Board in writing within seventy-two (72) hours after termination of any nursing employment. Any notification of termination shall contain a full explanation of the circumstances surrounding it.

8. The Board shall be informed of and approve of the level of supervision provided to the Respondent while he is

functioning as a registered nurse. The appropriate level of supervision must be approved by the Board prior to commencement of work. Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board.

9. Respondent may not work for a nurse registry, temporary nurse agency, home care agency, in-house nursing pool, as a nursing supervisor, as a faculty member in an approved school of nursing, or as an instructor in a Board approved continuing education program without the prior approval of the Board. Respondent must work only on regularly assigned, identified and predetermined worksite(s) with appropriate supervision as approved by the Board.

10. Respondent, at her expense, shall begin and successfully complete such courses in nursing as directed by the Board, including at least one course in nurse note-taking, prior to the end of the probationary term. The content of such courses and the place and conditions of instruction shall be specified by the Board representative at the time of the initial probation meeting based on the nature of Respondent's violations. Specific courses must be approved prior to enrollment. The Respondent must submit written proof of enrollment and proof of successful completion. Transcripts or certificates of completion must be mailed directly to the Board by the agency or entity instructing the Respondent. Home study or correspondence courses are not acceptable and will not be approved.

11. If Respondent violates the terms and conditions of his probation, the Board, after giving Respondent notice and an opportunity to be heard, may set aside the stay order and impose the revocation of Respondent's license.

12. If during the period of probation, an Accusation or Petition to Revoke Probation has been filed against Respondent's license, the probation period shall automatically be extended and shall not expire until the Accusation or Petition to Revoke Probation has been acted upon the Board.

13. Upon successful completion of probation, Respondent's license shall be fully restored.

Dated: April 26, 1994

JAIME RENÉ ROMÁN
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CHERYL DIANE ARTIAGA 4701 Claire Del Avenue Long Beach, California 90807 Registered Nurse License No. 326819 Respondent.	NO. 93-31 ACCUSATION

Catherine M. Puri, R.N., Ph.D., for causes for discipline, alleges:

1. Complainant Catherine M. Puri, R.N., Ph.D., makes and files this accusation in her official capacity as Executive Officer, Board of Registered Nursing, Department of Consumer Affairs.

2. On March 31, 1981, the Board of Registered Nursing issued registered nurse license number 326819 to Cheryl Diane

Artiaga. The license will expire January 31, 1993, unless renewed.

3. Under Business and Professions Code section 2750, the Board of Registered Nursing may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 of the Nursing Practice Act.

Under Business and Professions Code section 2764, the expiration of a license shall not deprive the Board of Registered Nursing of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the licensee.

4. "Drugs"

"Demerol," a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(16).

5. Respondent has subjected her license to discipline under Business and Professions Code section 2761(a) on the grounds of unprofessional conduct as defined in section 2762(e) of that code in that while employed as a registered nurse at Saint Vincent's Medical Center, Los Angeles, California, through First Choice Registry, Los Angeles, California, she falsified, made grossly inconsistent, grossly incorrect or unintelligible entries in hospital or patient records pertaining to Demerol, a controlled substance, in the following respects:

a. On April 7, 1989, (incorrectly signed out as 7/7/89), at a time unintelligible, on line 3, on the Narcotic and Controlled Drug Administration Record, she signed out 50 mg. of Demerol for patient L.B., but failed to chart the administration on the patient's medication administration record and the administration would be inconsistent with physician's orders which did not call for the administration of this medication.

a. On April 7, 1989, (incorrectly signed out as 7/7/89), on line 2, on the Narcotic and Controlled Drug Administration Record, she signed out 50 mg. of Demerol, but she failed to note the time she was signing out the medication, and the name of the patient, room number of the patient and the physician's name was unintelligible.

c. On April 7, 1989, (incorrectly signed out as 7/7/89), on line 1, on the Narcotic and Controlled Drug Administration Record, she signed out 50 mg. of Demerol, but she failed to note the time she was signing out the medication, the physician's name was unintelligible and the administration of this medication was inconsistent with physician's orders which did not call for the administration of this medication.

WHEREFORE, complainant prays a hearing be had and that the Board of Registered Nursing make its order:

1. Revoking or suspending registered nurse license number 326819, issued to Cheryl Diane Artiaga.

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2. Taking such other and further action as may be deemed appropriate.

DATED: Aug 27, 1992

Catherine M Puri

CATHERINE M. PURI, R.N., Ph.D.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CHERYL DIANE BOYD aka CHERYL DIANA ARTIAGA 1777 S. Ogden Drive Los Angeles, California 90019 Registered Nurse License No. 326819 Respondent.	NO. 93-31 FIRST SUPPLEMENTAL ACCUSATION

Ruth Ann Terry, R.N., M.P.H., for further causes for discipline, alleges:

1. Complainant Ruth Ann Terry, R.N., M.P.H., makes and files this first supplemental accusation in her official capacity as Executive Officer, Board of Registered Nursing, Department of Consumer Affairs.

2. On March 31, 1981, the Board of Registered Nursing issued registered nurse license number 326819 to Cheryl Diane

Artiaga (now Cheryl Diane Boyd). The license will expire January 31, 1995, unless renewed.

3. Under Business and Professions Code section 2750, the Board of Registered Nursing may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 of the Nursing Practice Act.

Under Business and Professions Code section 2764, the expiration of a license shall not deprive the Board of Registered Nursing of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the licensee.

4. "Drugs"

"Demerol," a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(16).

"Ativan," a brand of lorazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(11).

5. Respondent has subjected her license to discipline under Business and Professions Code section 2761(a) on the grounds of unprofessional conduct as defined in section 2762(e) of that code in that while employed as a registered nurse at Robert F. Kennedy Medical Center, Hawthorne, California, she falsified, made grossly inconsistent, grossly incorrect or

unintelligible entries in hospital or patient records pertaining to Demerol and Ativan, controlled substances, in the following respects:

a. On July 31, 1993, on line 4, at 0800, on Controlled Substances Administration Record No. 23641, she signed out 75 mg. of Demerol for patient B.G., but failed to chart the reason the medication was administered on the patient's nursing notes, falsely entered on the patient's medication administration record that Dr. Ragland had ordered that medication for patient B.G. and the administration would be inconsistent with the physician's orders which did not call for the administration of this medication.

b. On July 31, 1993, on line 5, at 1200, on Controlled Substances Administration Record No. 23641, she signed out 75 mg. of Demerol for patient B.G., but failed to chart the reason the medication was administered on the patient's nursing notes, falsely entered on the patient's medication administration record that Dr. Ragland had ordered that medication for patient B.G. and the administration would be inconsistent with the physician's orders which did not call for the administration of this medication.

c. On July 31, 1993, on line 8, at 1700, on Controlled Substances Administration Record No. 23641, she signed out 75 mg. of Demerol for patient C.F., but failed to chart the reason the medication was administered on the patient's nursing notes and the administration would be inconsistent with the physician's orders which did not call for the administration of this

medication.

d. On July 31, 1993, on line 9, at 1830, on Controlled Substances Administration Record No. 23641, she signed out 75 mg. of Demerol for patient C.F., but failed to chart the administration on the patient's medication administration record, the reason the medication was administered on the patient's nursing notes and the administration would be inconsistent with the physician's orders which did not call for the administration of this medication.

e. On July 31, 1993, on line 6, at 1400, on Controlled Substances Administration Record No. 23641, she signed out 75 mg. of Demerol for patient I.B., but failed to chart the administration on the patient's medication administration record.

f. On July 31, 1993, on line 7, at 1800, on Controlled Substances Administration Record No. 23641, she signed out 75 mg. of Demerol for patient I.B., but failed to chart the administration on the patient's medication administration record.

WHEREFORE, complainant prays that this first supplemental accusation be heard at the same time and place as the accusation and that the Board of Registered Nursing make its order:

1. Revoking or suspending registered nurse license number 326819, issued to Cheryl Diane Boyd aka Cheryl Diane Artiaga.

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2. Taking such other and further action as may be deemed appropriate.

DATED: October 6, 1993

/s/ Ruth Ann Terry (GM)
RUTH ANN TERRY, R.N., M.P.H.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

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